U.S. Public Health Service Commissioned Corps Readiness Force Student Application

Please initial next to each line on the form below confirming that you have met the CCRF course prerequisites. Fax this page along with your completed course application and a copy (front and back) of your BLS for Healthcare Providers card to the CCRF fax number on the following page.

INITIAL	CCRF REQUIREMENTS								
	Own at least 2 complete pairs of the Working Khaki uniform.								
	APPLICATION PREREQUISITES								
	Supervisor's permission to attend.								
	Own at least 2 complete pairs of the woodland BDUs.								
	Completed physical exam (including medical review) on file with DCP within past 5 years.								
	Certified in AHA BLS for Healthcare Providers and recorded on CCRF Officer Summary Page. You must fax a copy of your BLS card (front and back) with your application.								
	Current licensure (if applicable) on file with DCP and recorded on CCRF Officer Summary Page.								
	Immunization requirements completed (Hep A + B series started) and recorded on CCRF Officer Summary Page.								
	Current APFT recorded on CCRF Officer Summary Page.								
	Recorded height and weight on CCRF Officer Summary Page.								
	Recorded the number of hours you practice your professional skill on CCRF Officer Summary Page.								
	Current login and update of CCRF Officer Summary Page.								
	Completion of most or all sessions on the CCRF Online Training Program.								



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12300 Twinbrook Parkway · Suite 360 · Rockville, MD 20857 Fax (301) 443-3119



PPLICATIONS MUST BE TYPEWRITTEN	(YOU MUST FILL IN EACH FIEL

Course Title:					Course Date: Select only ONE course date					
Combat Casualty Care Course (C4)					☐ Oct 16- 24 ☐ Oct 30-Nov 7 ☐ Nov 13-21					
Management of Chemical & Biological Casualties (MMCBC) ☐ November 1 - 8										
PHS Serial Num (SERNO)	ber		S.S.N.			# Clinical Hours BL Within the past 12 months		S for Healthcare Provider Expiration Date		
								1	1	
Name					Rank:			PHS Category:		
LAST: FIRST:										
Home Address:				City, State, Zip Code:						
				,	, ,					
Home E-Mail:				Нот	no Dhono:			Mahila/Dagay		
HOITIE E-IVIAII.				Home Phone:				Mobile/Pager:		
Duty Station Address	c			City, State, Zip Code:						
Duty Station Address				Gity, State, Zip Gode.						
Work E-Mail:				Work Phone:				Work Fax:		
OPDIV/Agency:				Current Job Title:						
Orbivingelicy.										
Mode of Transportat	tion: chec	k applicable	If traveling by a	air, please specify Airports of Departure :						
□ Automobile		Air Travel	1 st Choice	2 nd Choice						
Have you attended	d this co	ourse in the nas	t?							
□ No □ Yes		when?								
Why do you think you should be selected for this course?										
Supervisor's Name				Supe	Supervisor's Signature				Date	